

Michigan Medicaid Nursing Facility Level of Care Determination

Applicant's
Name:_____
(Last) (First) (M.I.)Provider
Type:_____
Medicaid ID: _____Medicaid
ID:

Provider
Contact
Name:_____
(Last) (First)Date of
Birth:_____/_____/_____
00 / 00 / 0000Provider
Day
Phone:()
_____-_____

Door 1: Activities of Daily Living

A. Bed Mobility: How the applicant moves to and from lying position, turns side to side, and positions body while in bed (sleeping surface).

- Field 8** ☐ **Independent**
No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days.
- Field 9** ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.
- Field 10** ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.
- Field 11** ☐ **Extensive Assistance**
While the applicant performed part of activity over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
 - Full performance by another during part, but not all, of last 7 days
- Field 12** ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.
- Field 13** ☐ **Activity did not occur** during entire 7 days (regardless of ability).

B. Transfers: How the applicant moves between surfaces, to/from bed (sleeping surface), chair, wheelchair, standing position (exclude to/from bath/toilet).

- Field 14** ☐ **Independent**
No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days.

- Field 15** ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.
- Field 16** ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.
- Field 17** ☐ **Extensive Assistance**
While the applicant performed part of activity over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
 - Full performance by another during part, but not all, of last 7 days
- Field 18** ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.
- Field 19** ☐ **Activity did not occur** during entire 7 days (regardless of ability).

C. Toilet Use: How the applicant uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

- Field 20** ☐ **Independent**
No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days.
- Field 21** ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.
- Field 22** ☐ **Limited Assistance**
Applicant highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.
- Field 23** ☐ **Extensive Assistance**
While the applicant performed part of activity over last 7-day period, help of following types(s) provided 3 or more times:
- Weight-bearing support
 - Full performance by another during part, but not all, of last 7 days
- Field 24** ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.
- Field 25** ☐ **Activity did not occur** during entire 7 days (regardless of ability).

D. Eating: How the applicant eats and drinks (regardless of skill). Includes intake of nourishment by other means (i.e., tube feeding, total parenteral nutrition).

- Field 26** ☐ **Independent**
No help or oversight, OR help or oversight provided only 1 or 2 times during last 7 days.
- Field 27** ☐ **Supervision**
Oversight, encouragement or cueing provided 3 or more times during last 7 days, OR supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days.

- Field 28** ☐ **Limited Assistance**
Applicant received physical help in guided maneuvering of limbs or other assistance 3 or more times, OR more help provided only 1 or 2 times during last 7 days.
- Field 29** ☐ **Extensive Assistance**
While the applicant performed part of activity over last 7-day period, help of the following type provided 3 or more times:
- Full performance by another during part, but not all, of last 7 days
- Field 30** ☐ **Total Dependence**
Full performance of activity by another during entire 7 days.
- Field 31** ☐ **Activity did not occur** during entire 7 days (regardless of ability).

Scoring Door 1: The applicant must score at least six points to qualify under Door 1.

(A) Bed Mobility, (B) Transfers, and (C) Toilet Use:

- Independent or Supervision = 1
- Limited Assistance = 3
- Extensive Assistance or Total Dependence = 4
- Activity Did Not Occur = 8

(D) Eating:

- Independent or Supervision = 1
- Limited Assistance = 2
- Extensive Assistance or Total Dependence = 3
- Activity Did Not Occur = 8

Door 2: Cognitive Performance (Does the applicant have any problems with memory or making decisions?)

A. Short-term memory okay (seems/appears to recall after 5 minutes)

- Field 32** ☐ **Memory Okay**
- Field 33** ☐ **Memory Problem**

B. Cognitive skills for daily decision-making (made decisions regarding tasks of daily life for last 7 days).

- Field 34** ☐ **Independent**
The applicant's decisions were consistent and reasonable (reflecting lifestyle, culture, values); the applicant organized daily routine and made decisions in a consistent, reasonable, and organized fashion.
- Field 35** ☐ **Modified Independent**
The applicant organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.
- Field 36** ☐ **Moderately Impaired**
The applicant's decisions were poor; the applicant required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- Field 37** ☐ **Severely Impaired**
The applicant's decision-making was severely impaired, the applicant never (or rarely) made decisions.

C. Making self understood (expressing information content, however able).

Field 38 ☐ **Understood**

The applicant expresses ideas clearly, without difficulty.

Field 39 ☐ **Usually Understood**

The applicant has difficulty finding the right words or finishing thoughts, resulting in delayed responses. If given time, little or no prompting required.

Field 40 ☐ **Sometimes Understood**

The applicant has limited ability, but is able to express concrete requests regarding at least basic needs (i.e., food, drink, sleep, toilet).

Field 41 ☐ **Rarely/Never Understood**

At best, understanding is limited to interpretation of highly individual, applicant-specific sounds or body language (i.e., indicated presence of pain or need to toilet).

Scoring Door 2: The applicant must score under one of the following three options to qualify under Door 2.

1. "Severely Impaired" in Decision Making.
2. "Yes" for Memory Problem, and Decision Making is "Moderately Impaired" or "Severely Impaired."
3. "Yes" for Memory Problem, and Making Self Understood is "Sometimes Understood" or "Rarely/Never Understood."

Door 3: Physician Involvement (Is the applicant under the care of a physician for treatment of an unstable medical condition?)

Field 42 **A. Physician Visits:** In the last 14 days, how many days has the physician, or authorized assistant or practitioner, examined the applicant? **Do not** count emergency room exams. Enter "0" if none.

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Field 43 **B. Physician Orders:** In the last 14 days, how many days has the physician, or authorized assistant or practitioner, changed the applicant's orders? **Do not** include drug or treatment order renewals without change. Enter "0" if none.

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Scoring Door 3: The applicant must meet either of the following to qualify under Door 3.

1. At least one Physician Visit exam AND at least four Physician Order changes in the last 14 days, OR
2. At least two Physician Visit exams AND at least two Physician Order changes in the last 14 days.

Door 4: Treatments and Conditions (Has the applicant in the last 14 days received any of the following health treatments, or demonstrated any of the following health conditions?)

Complete each item below, either Yes or No.

		Yes	No
Field 44/45	A. Stage 3-4 pressure sores	<input type="checkbox"/>	<input type="checkbox"/>
Field 46/47	B. Intravenous or parenteral feedings	<input type="checkbox"/>	<input type="checkbox"/>
Field 48/49	C. Intravenous medications	<input type="checkbox"/>	<input type="checkbox"/>
Field 50/51	D. End-stage care	<input type="checkbox"/>	<input type="checkbox"/>
Field 52/53	E. Daily tracheostomy care, daily respiratory care, daily suctioning	<input type="checkbox"/>	<input type="checkbox"/>
Field 54/55	F. Pneumonia within the last 14 days	<input type="checkbox"/>	<input type="checkbox"/>
Field 56/57	G. Daily oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
Field 58/59	H. Daily insulin with two order changes in last 14 days	<input type="checkbox"/>	<input type="checkbox"/>
Field 60/61	I. Peritoneal or hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>

Scoring Door 4: The applicant must score "yes" in at least one of the nine categories and have a continuing need to qualify under Door 4.

Door 5: Skilled Rehabilitation Therapies (Is the applicant currently receiving any skilled rehabilitation therapies?)

Record the total minutes each of the following therapies was administered or scheduled (for at least 15 minutes a day) in the last 7 days. Enter "0" if none or less than 15 minutes daily.

A = Total number of minutes provided in last 7 days

B = Total number of minutes scheduled but not yet administered

	A	B
1. Speech Therapy	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Fields	62	63
2. Occupational Therapy	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Fields	64	65
3. Physical Therapy	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Fields	66	67

Example:

A	B
<input type="text"/> 2 <input type="text"/> 1 <input type="text"/> 0	<input type="text"/> 6 <input type="text"/> 0

Scoring Door 5: The applicant must have required at least 45 minutes of active ST, OT or PT (scheduled or delivered) in the last 7 days and continues to require skilled rehabilitation therapies to qualify under Door 5.

Door 6: Behavior (Has the applicant displayed any challenging behaviors in the last 7 days?)

Behavioral Code:

- 0 = Behavior not exhibited in last 7 days
- 1 = Behavior of this type occurred 1 to 3 days in last 7 days
- 2 = Behavior of this type occurred 4 to 6 days, but less than daily
- 3 = Behavior of this type occurred daily

Behavioral Symptoms:

	0	1	2	3
A. Wandering - Moved with no rational purpose, seemingly oblivious to needs and safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fields	68	69	70	71
B. Verbally Abusive - Others were threatened, screamed at, cursed at.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fields	72	73	74	75
C. Physically Abusive - Others were hit, shoved, scratched, sexually abused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fields	76	77	78	79
D. Socially Inappropriate/Disruptive - Made disruptive sounds, noisiness, screaming, self-abusive acts, inappropriate sexual behavior or disrobing in public, smeared or threw food/feces, hoarded or rummaged through others' belongings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fields	80	81	82	83
E. Resists Care - Resisted taking medications or injections, ADL assistance or eating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fields	84	85	86	87

Problem Condition Code: If present at any point in last 7 days, code either Yes or No.

Problem Conditions:

	Yes	No
A. Delusions	<input type="checkbox"/>	<input type="checkbox"/>
Fields	88	89
B. Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Fields	90	91

Scoring Door 6: The applicant must score under one of the following 2 options to qualify under Door 6.

1. A "Yes" for either delusions or hallucinations within the last 7 days.
2. The applicant must have exhibited any one of the following behaviors for at least 4 of the last 7 days (including daily): Wandering, Verbally Abusive, Physically Abusive, Socially Inappropriate/Disruptive, or Resisted Care.

Door 7: Service Dependency

The applicant is currently being served by either the MI Choice Program, PACE program or Medicaid reimbursed nursing facility.

Field 92 ☐ **Program participant for at least one year** and requires ongoing services to maintain current functional status. You may combine time the applicant received services across the three programs. No other community, residential or informal services are available to meet the applicant's needs.

Field 93 ☐ **Not a program participant for one year.**

Scoring Door 7: The applicant must be a current participant and demonstrate service dependency to qualify under Door 7.

FREEDOM OF CHOICE

Applicant's Name: _____ Date of Birth: _____

Representative (if any): _____

SECTION I – FUNCTIONAL/MEDICAL ELIGIBILITY

Based on an assessment of functional abilities and needs conducted on _____, the applicant indicated above: (date)

Field 98

☐ **Does** meet the functional/medical eligibility criteria for Medicaid LTC programs by scoring in Door _____.

Field 100

☐ **Does Not** meet the functional/medical eligibility criteria for Medicaid NF Level of Care (please proceed to Section III) **Field 101**

Signature of professional completing assessment

Title

Date

SECTION II - FREEDOM OF CHOICE

I have been advised that I meet functional/medical eligibility and have requested and received information about the following programs:

Field 105 ☐ MI Choice Program. I have received local referral information.

**Local
Referrals:**

Field 107 ☐ Nursing facility care. I have received information about nursing facilities in my area.

Field 108 ☐ PACE Program. I have received information about the PACE program.

Signature of applicant

Signature of applicant's representative

Date

SECTION III - APPEAL RIGHTS

I have received a copy of a denial of service based on this determination and understand my right to appeal.

Signature of applicant

Signature of applicant's representative

Date

Option Screen from Section I "Eligibility Option Button" of Freedom of Choice form:

Field 116 ☐ Please hold this review for 30 days. The provider will contact the vendor for an exception request.

Field 117 ☐ A formal adverse action notice has been provided. The applicant has been referred for other community program options to:
